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ARIZONA STATE VETERINARY MEDICAL EXAMINING BOARD
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INVESTIGATIVE COMMITTEE REPORT

TO: Arizona State Veterinary Medical Examining Board

FROM: PM Investigative Committee: Adam Almaraz - Chair
Amrit Rai, DVM
Cameron Dow, DVM
Brian Sidaway, DVM

STAFF PRESENT: Tracy A. Riendeau, CVT - Investigations
Marc Harris, Assistant Attorney General

RE: Case: 21-47
Complainant(s): Frederick Milens/Ashanna Biliter
Respondent(s): Jonathan Schnier, DVM (License: 4167)

SUMMARY:
Complaint Received at Board Office: 10/16/20
Committee Discussion: 4/6/21
Board IIR: 5/19/21

APPLICABLE STATUTES AND RULES:
Laws as Amended August 2018 (Lime Green); Rules as Revised September 2013 (Yellow)

On June 19, 2020, "C[redacted]" a 14-year-old male Pomeranian was presented to 1st Pet Veterinary Centers after two day history of collapsing. The dog had multiple medical issues and was under the care of an internal medicine specialist and neurologist.

Diagnostics were conducted; it was initially suspected the dog had IMHA and a blood transfusion was eventually performed at BluePearl.

The dog continued to decline, was evaluated and hospitalized for care and treatment at 1st Pet Veterinary Centers for possible seizures. The dog was obtunded and worsened despite treatment. All of the dog's care providers were concerned with the dog's prognosis and quality of life due to the dog's mental status not returning.

On June 26, 2020, Complainants elected to humanely euthanize the dog.

Complainants were noticed and appeared telephonically with attorney, Kyle O'Dwyer.
Respondent was noticed and appeared telephonically. Attorney David Stoll appeared.

The Committee reviewed medical records, testimony, and other documentation as described below:

- Complainant(s) narrative: Frederick Milens/Ashanna Biliter
- Respondent(s) narrative/medical record: Jonathon Schniew, DVM
- Consulting Veterinarian(s) narrative/medical records: Jill Patt, DVM

PROPOSED 'FINDINGS of FACT':

With respect to Dr. Schnier, Complainant expressed concerns that Dr. Schnier was not available to assist emergency care providers as he had indicated. Complainants state that if they knew he would not be available to update emergency care providers, they would have sought out different options for the dog care to ensure he had the best chance of surviving his continuing medical issues. Additionally, Dr. Schnier did not follow up with his recommendations or convey them to Complainants in a timely manner. By performing additional diagnostics, Complainants felt they would be able to determine whether it was necessary to euthanize the dog

1. Dr. Schnier stated that he had worked with the complainants since the fall of 2018 as an internal medicine specialist. At that time, the dog was evaluated at VETMED where he was diagnosed with a pheochromocytoma involving his left adrenal gland. The pheochromocytoma was resected by a surgeon at UC Davis in December 2018. Dr. Schnier continued to work with the dog and his owners since that time and had re-evaluated the dog numerous times at VETMED and later at BluePearl.

2. Dr. Yeamans stated in her narrative that the dog had been under her premises's care for progressive seizure disorder and suspected meningoencephalitis of unknown origin since November 2019.

3. On June 19, 2020, Friday, (approx. 4:30pm) the dog was presented to Dr. Meredith at 1st Pet Veterinary Centers after collapsing. The dog had a history of multiple medical issues and had been on a combination of seizure medication. Complainants reported that the dog laid lateral in the yard and had turned his head to the side. The dog also had two previous episodes at home that started the night before. There was also an episode that happed later in the day where the dog had urinated on himself and turned pale. Upon exam, Dr. Meredith noted the dog was responsive, had muddy gums and breathing difficulties. The dog's neurological exam was abnormal – non menace response in either eye. The dog's heart rate was low and lungs harsh. An IV catheter was placed and the dog was put in an oxygen chamber.

4. On intake the dog had a respiration rate = 30rpm, white mucous membranes, pulse rate = 80bpm (the minutes later 150bpm); temperature = unable to obtain. After being placed in the oxygen chamber, ECG revealed a normal rhythm and rate, as well as normal blood pressure. Once the dog had received oxygen therapy, blood was collected for testing and thoracic radiographs were performed.

5. Radiographs revealed a mildly enlarged heart with a bronchial pattern worse in the left lung fields, spondylosis, and aeophagia. The radiology report noted collapse of the left bronchius, enlarged liver, and some abnormal gastric contents. Blood work revealed anemia (PCT – 22%, RBC – 2.47), and a saline agglutination test was run and there was a concern for agglutination.

6. Dr. Meredith discussed the abnormal findings with Complainants. Complainants advised Dr. Meredith that the dog had kidney disease as well as a left sided stroke and absent menace of the right eye. Dr. Meredith relayed the possibility of immune mediated hemolytic anemia (IMHA) due to the anemia and elevated WBC - she felt that primary IMHA was unlikely due the dog's age, and secondary IMHA could be related to an underlying infection, medications, cancer, and other. Dr. Meredith also expressed concern for pulmonary thromboembolism (PTE), considering the dog's history of stroke and oxygen dependence.

7. Dr. Meredith discussed at length possible underlying causes, and that they could treat with steroids, antibiotics, and oxygen at that time. They would continue to monitor the dog's response. Due to the dog's myriad of other health issues, the dog's prognosis was guarded to poor, and Complainants were advised that if the dog continued to have issues, they may need to discuss the dog's quality of life. Complainants understood and approved the plan for hospitalization. The dog was hospitalized on IV fluids 8.8mLs/hr (unclear on type).

8. At 7:00pm, Dr. Meredith's associate, Dr. Deer, took over the care of the dog. Dr. Deer stated in her narrative that dog had an extensive history of hydrocephalus, seizures, Chiarai malformation, syringomyelia, medially luxating patellas, hypertension, hypothyroidism, collapsing trachea, IVDD, a surgically removed pheochromocytoma a few years prior, and a suspected fractured right thoracic limb (prior to adoption of the dog). The dog had elevated renal values that have been identified by the regular veterinarian earlier in the year. The night before presentation the dog had a seizure with collapse and white mucous membranes. The dog had been unable to stand which was normal for him as he had not been ambulatory for some time.

9. After Dr. Deer reviewed Dr. Meredith's findings (blood work and radiograph results), she examined the dog and found a weight = 3.4kg, a temperature = 98.2 degrees, a heart rate = 170bpm and a respiration rate = 40rpm; pale mucous membranes. Dr. Deer stated the dog was quiet, alert, and responsive; although the dog became tachypneic during the exam but was not in respiratory distress. The dog was non-ambulatory and Dr. Deer did not perform a full neurologic exam due to the dog needing to be in the oxygen chamber. The dog was offered food and water – ate well – and was medicated with prednisone, zonisamide, levothyroxine, imepitoin, flowvent, and telmisartan at 8pm.

10. That evening, dog was also administered Ampicillin, levetiracetam and dexamethasone

sodium phosphate IV.

11. In the early morning, blood work was repeated. When removed from the oxygen kennel the dog would become stressed therefore the dog remained on oxygen. Blood work revealed PCV 20% and Dr. Deer contacted Complainants. She relayed the worsening anemia and the differential diagnosis of IMHA and causes. Complainants asked if the zonisamide or phenobarbital could be the cause – Dr. Deer thought it was unlikely but they could try tapering zonisamide if recommended by the neurologist, but the dog would at risk for continued seizures. Additionally, stopping the zonisamide would not slow the IMHA if that was the cause. Due to the worsening anemia, blood transfusion was discussed as a possibility as well as the dog's quality of life and humane euthanasia. Complainants were not interested in humane euthanasia at that time.

12. Complainant requested Dr. Deer reach out to Dr. Schnier – internal medicine at BluePearl Avondale - and Dr. Yeamans – neurologist at ANIC – to discuss next steps. Dr. Deer explained that she would not be able to get ahold of either of them at that time (1am) but she would call BluePearl to update them. Within the hour, Dr. Deer called BluePearl to advise the dog was currently being hospitalized with them and to let Dr. Schnier know that Complainants were interested in consulting with him.

13. On June 20, 2020, at approximately 6:30am, Dr. Deer contacted Complainants with an update on the dog. She advised that the dog was still on oxygen therapy and that she had reached out to BluePearl to let them know the dog was hospitalized with them. It was unlikely they would get a consult on the weekend, but they would let Dr. Schnier know. Dr. Deer discussed the plan of potentially lowering the zonisamide and that the blood work was partially consistent with IMHA but was not the definitive diagnosis. Shortly after the call, the dog's care was transferred to Dr. Meredith.

14. At 8:00am, the dog was medicated with the owner's medication and Dr. Meredith continued supportive care for the dog throughout the day.

15. At 11:00am the dog had a PCV = 22% and at 3:00pm the dog had a PCV at 23%. Attempts were made to wean the dog off oxygen throughout the day. Complainants visited the dog and elected to take the dog home as he appeared more relaxed while with them. Dr. Meredith recommended Complainants keep their previously scheduled appointment with Dr. Schnier on Monday. The dog was discharged to Complainants.

16. On June 21, 2020, at 4:00am, the dog presented to Dr. Deer at 1st Pet Veterinary Centers due to another episode of collapse. Complainants reported that they took the dog outside where he collapsed, was pale and non-responsive. According to Dr. Deer, she evaluated the dog – he was QAR, unable to ambulate, was tachypnic, and had mild to moderate increased abdominal effort with an increase in bronchovesicular sounds in all lungs. The dog had a PCV – 22% consistent with the last reading the previous day. Could not locate the

medical record for this day.

17. Dr. Deer spoke with Complainants and discussed that the dog appeared to be back to the same condition he was the previous day. They discussed causes of the dog's collapse and hospitalization for care until the evaluation at BluePearl. They further discussed a cardiology consult to evaluate pulmonary hypertension and if there was cardiac issues. Complainants were interested in the cardiology consult. Since it was Sunday at 4am, Dr. Deer explained that it was unlikely they could secure a consult right away. The dog was given back to Complainants to wait in the car while Dr. Deer reached out to specialists.

18. Dr. Deer reached out to Dr. Church – he was out of town; she contacted VETMED and was advised that an echocardiogram and cardiology consult was unlikely on Sunday or Monday. Dr. Deer reported her unsuccessful attempts to find a cardiology consult for Complainants and recommended follow up care at VETMED until the cardiologist could evaluate the dog. Complainants elected to take the dog home and monitor him.

19. Complainants called BluePearl to advise the dog was being seen at 1st Pet Veterinary Centers in Mesa and asked if Dr. Schnier could call and discuss the dog's care with the vets at 1st Pet Veterinary Centers. BluePearl staff advised Complainants that Dr. Schnier was not on-call but they would text Dr. Schnier and let him know the issues the dog was having. However, the dog issues were new and Dr. Schnier would not be able to provide any information other than the dog's history. BluePearl staff would call 1st Pet Veterinary Centers to discuss.

20. BluePearl staff called 1st Pet Veterinary Centers and spoke with Dr. Deer. She was advised that Dr. Schnier was not on call all the time but would be texted to update him on the dog. Dr. Deer reported that the dog had been presented a few days ago and it was recommended Complainants follow up with an internal medicine doctor which was not done – however the dog would be seen on Monday. Dr. Deer further stated that Complainants were having difficulty understanding that it might be time.

21. Complainants stated that Dr. Deer did not inform them of her opinion at that time. If she had, they would have had sought out a different provider.

22. At 7:00pm that evening, Dr. Deer returned to work. She had a message from Complainants; she returned the call and was told that the dog was okay but sedate. They were unsure if the dog was sedate due to the illness or the medications – the dog was resting well and eating and drinking.

23. On June 22, 2020, the dog was presented to Dr. Schnier for evaluation. Dr. Schnier reviewed the dog's diagnosis/problem list:

a. Hind limb neuropathy/myopathy;
b. Pheochromocytoma;

c. Tracheal Collapse at level of mainstem bronchus and intrathoracic;
d. Spondylosis Deformans Multilevel – cervical – sever, LS – mild;
e. Hydrocephalus – congenital COMS;
f. Patella luxation bilateral;
g. Previous right front leg trauma with resultant valgus deformity;
h. History of seizures with recent onset of grand mal and focal seizures;
i. Intermittent hyponatremia/hypochloremia/hyperkalemia;
j. Hypothyroid;
k. Proteinuria;
l. Cortical blindness OD;
m. History of hypertension – now borderline hypotensive;
n. Recent onset of lethargy, intermittent collapse and vomiting;
o. Elevated Spec cPl consistent with pancreatitis;
p. New onset of severe non-regenerative anemia;
q. Leukocytosis with a mild left shift;
r. Concern for pulmonary hypertension; and
s. Generalized poor lung inflation.

24. Dr. Schnier reviewed the dog's recent history of collapse and apnea. He was treated at 1st Pet Veterinary Centers and severe non-regenerative anemia was identified. The dog had been hospitalized for diagnostics and treatment. No blood transfusion was performed at that time. After discharge, the dog had another episode of collapse with a period of apnea. Dr. Schnier mentioned that the dog may have experienced a mild seizure following one of his episodes – Complainants reported that the dog had been experiencing seizures every 5 – 6 weeks. Previous seizure was in May and the last cluster seizure occurred in March. The dog was on the following medications:

a. Imepitoin;
b. Levetiracetam;
c. Zonisamide;
d. Prednisone;
e. Omeprazole;
f. Levothyroxine;
g. Telmisartan;
h. Amlodipine;
i. FloVent;
j. Denamarin;
k. Clavacillin;
l. Hydrocodone;
m. Entyce; and
n. Diazepam rectal gel.

25. Dr. Schnier examined the dog (W-3.5kg, T-103.2, P-120, R-90); he noted that the dog was

subdued but responsive. He was unable to walk in the hospital and demonstrated difficulty standing – carpal valgus was noted, mostly in the right forelimb. The hind limbs contracted forward. Mucous membranes were pink and a soft grade II/VI left systolic murmur was suspected on auscultation with a sinus arrhythmia. Lungs ausculted clear in all fields although intermittent episodes of panting and tachypnea were noted with increased respiratory effort at times.

26. Dr. Schnier performed radiographs and an ultrasound on the dog. Radiographs revealed generalized poor lung inflation consistent with recumbency and possibly exacerbated by concurrent tracheal collapse. Associated right cranial atelectasis. Concurrent mild diffuse tracheobronchitis and mild right cranial pneumonia were possible. There was a nonspecific hepatopathy which could be associated with any infiltrative process. Elbow arthritis, Patella luxation, and multifocal cervical and thoracolumbar IVDD.

27. Abdominal ultrasound revealed:
Mild to moderate hepatomegaly was noted with hyperechoic parenchyma. The hepatic changes were suspected to represent a vacuolar hepatopathy. This could have been associated with chronic prednisone administration or possibly, underlying endocrine/metabolic disease. Bilateral renal changes were noted, consistent with chronic kidney disease. Renal size appeared to be stable. Two small non-deforming hypoechoic nodules were noted. The splenic nodules appeared to be consistent with a benign process. No abnormalities were noted to account for the dog's signs of anemia. Primary differentials include gastrointestinal blood loss vs hemolytic anemia.

28. Blood work and a urinalysis were performed. PCV = 23%; HCT = 17.8%; Cardiopet NT – proBNP -2407; fecal occult blood test – positive.

29. The dog was administered the following:
   a. Oxygen therapy;
   b. Iron dextran;
   c. Cobalamin; and
   d. LRS SQ;

30. Dr. Schnier discussed hospitalization and packed red blood cell transfusion with Complainants. Complainants wanted to avoid a transfusion at that time, however, a follow up appointment to have the dog's PCV rechecked on June 24th was scheduled. The dog was discharged with instructions for Complainants to monitor the dog and continue current medications but discontinue telmisartan and amolodipine. Complainants were to feed the dog a low-fat diet. Detailed discharge instructions were provided to Complainants with the dog's diagnostic results. An echocardiogram with a cardiologist was recommended and if the follow up blood work revealed progressive anemia, a blood transfusion could be warranted.

31. On June 23, 2020, the dog was presented to Dr. Matthews at VETMED for an echocardiogram. The echo revealed left ventricular hypertrophy, mild valve insufficiency and moderate pulmonary hypertension.

32. On June 24, 2020, the dog was presented to Dr. Schnier for a recheck. Upon exam, the dog had a weight = 3.4kg, a temperature = 101 degrees, a pulse rate = 132bpm and a respiration rate = 90bpm. The rest of the exam was noted to be the same as the June 22nd exam. PCV = 17%; TS – 6.2. Dr. Schnier discussed the blood results with Complainants and recommended a blood transfusion as the dog's anemia had progressed since 6/22. The dog would be hospitalized for the transfusion and if no complications occurred the dog would be discharged later that day.

33. The dog was hospitalized for the blood transfusion. No complications had occurred and the dog was discharged later that evening. During the hospitalization, the dog was also administered:

a. Sucralfate;
b. Levetiracetam;
c. Denamarin;
d. Orbax;
e. Dex SP;
f. Cyclosporine; and
g. Clopidogrel.

34. Discharge instructions were provided which were also discussed with Complainants. They stated that Dr. Yeamans was contacted regarding the dog's condition - she indicated that the zonisamide could have possibly triggered the dog's anemia and that it would be reasonably safe to discontinue zonisamide at this time. However, phenobarbital may need to be restarted if recurrent seizure activity was noted. The dog's fecal occult test was positive indicating a possibility of gastrointestinal bleeding; however, melena and GI signs would be expected with the dog's current level of anemia if GI bleeding was responsible for the dog's signs. A recheck PCV and blood pressure was recommended on June 26th or sooner if the dog was not doing well. Discharge instructions included a medication table that noted the recent changes to the dog's medications.

35. Dr. Schnier stated in his narrative that prior to discharge of the animal, he advised Complainants that BluePearl was staffed 24 hours a day with veterinarians and staff and they could call anytime with questions or concerns. If the call was outside normal business hours, they would speak with ER department staff. Dr. Schnier stated that he did not indicate that he would personally be in the hospital or available 24 hours to speak with Complainants directly. However, Dr. Schnier stated that he typically can be contacted by BluePearl staff by phone outside of his normal hours.

36. Later that evening, at 9:40pm, the dog was presented to Dr. Deer due to a suspected

seizure. The dog presented obtunded and minimally responsive. Complainants reported that the dog had a seizure at home and therefore rectal diazepam was administered. Upon exam, the dog had a weight = 3.3kg, a temperature = 104.2 degrees, a heart rate = 150bpm and a respiration rate = > 60rpm. Dr. Deer noted the dog appeared dehydrated based on tacky mucous membranes and prolonged skin tenting. The gums were pale and scant hematochezia was noted on the thermometer. An IV catheter was placed; the dog was started on Normosol – R fluids and placed on oxygen while Dr. Deer spoke with Complainants.

37. Dr. Deer stated in her narrative that she was frank with Complainants and expressed concerns about the chances of the dog surviving the night. Complainants felt the dog still had some fight left in him and approved overnight care. The dog was started on injectable levetiracetam since the dog was too obtunded to eat/swallow – oral medications were placed on the dog's treatment sheet with strict instructions to consult with the attending veterinarians prior to administration due to his obtunded status and high risk of choking. The dog's oral medications were not administered during her shift due to the dog being too obtunded to eat. Keppra and pantoprazole were given to the dog IV.

38. The dog remained obtunded throughout the night but the elevated temperature resolved with IV fluids and supportive care. Food was not offered as the dog was too obtunded to swallow.

39. At 12:44am (6/25), Complainants were updated and advised that there were no further seizures, the dog was in still in oxygen and critical. They asked about the dog's current PCV – Dr. Deer explained that the dog was not stable enough to remove from oxygen and collect a blood sample, which could put the dog at risk for another respiratory episode. While monitoring the PCV was important, Dr. Deer did not want to worsen the dog's condition.

40. At 5:00am, the dog appeared more sedate that previously – blood pressure was too low to read on the Doppler and his heart rate dropped to 70. Three doses of bolus fluids were administered which brought the dog's blood pressure up – the dog's PCV = 49%; TP = 5.

41. At 6:24am, Dr. Deer called Complainants when she felt the dog was stable enough to step away. She discussed the dog's episode of hypotension, bradycardia and the use of IV fluids. Dr. Deer relayed that there was a delicate balance of fluid overload due to the dog being diagnosed with pulmonary hypertension and mitral valve regurgitation recently. Additionally, the dog's PCV = 49% was indication that the dog's current symptoms were likely not related to anemia – pulmonary thromboembolism could be a possible cause of the dog's decline. Complainants commented that they wanted to see what the internal medicine doctor suggested as a next step. Dr. Deer explained that her associate, Dr. Meredith, would reach out to them once they open. The case was transferred to Dr. Meredith at 7:00am.

42. Dr. Meredith reviewed the case with Dr. Deer – since his last visit, the dog had been started on sildenafil by a cardiologist due to a diagnosis of pulmonary hypertension and due to the concern of IMHA the dog was taken off zonisamide. Dr. Meredith evaluated the dog and noted the dog was obtunded and laterally recumbent.

43. When Dr. Schnier arrived at work at BluePearl he had a message from Complainants – he called Complainants and was advised the dog was being hospitalized at 1st Pet Veterinary Centers. They discussed the dog's condition and Complainants requested Dr. Schnier call the veterinarians at 1st Pet Veterinary Centers to get an update. Complainants then asked if the dog should be transferred to BluePearl; Dr. Schnier responded that it may not be in the dog's best interest if he was not stable – 1st Pet should be able to provide the same level of care and treatment that BluePearl could provide. He stated that repeat advanced imaging of the dog's head and thoracic cavity could potentially provide additional information although advanced imaging was not available at BluePearl. Re-evaluation by the neurologist could be helpful but the dog would need to be stabilized prior to considering an MRI or CT.

44. Dr. Meredith spoke with Complainants that afternoon and expressed her concerns for the dog. The dog's mentation was not appropriate and had declined significantly from when she has seen him last. They discussed the ability of the dog to swallow at that time and Complainants requested the dog remain on oral keppra instead of injectable. Dr. Meredith was not convinced this would have any effect on the dog's mentation but they could try it.

45. Dr. Schnier then called Dr. Meredith to discuss the case – he suggested thoracic radiographs and Dr. Meredith stated that she would consider that diagnostic. At that time, she reported the dog remained obtunded although he was able to take oral medications. Dr. Schnier thought the dog's current state could be related to post-ictal event associated with seizures, and anticonvulsant treatment. He was also concerned about a stroke-like event and discussed that a CT or MRI could be considered for further evaluation if possible. Dr. Schnier and Dr. Meredith shared their concerns with the dog's quality of life. Dr. Schnier noted if there was a concern for pulmonary thromboembolism or ischemic stroke, treatment with enoxaparin could be added in addition to clopidogrel. Dr. Meredith stated she would keep them updated and discuss the details of their conversation with Complainants.

46. Dr. Meredith also spoke with Dr. Yeamans, the neurologist, regarding the case. Dr. Meredith stated that Dr. Yeamans also had concerns with the dog's mentation and quality of life. She felt the dog would either recover, or worsen. The dog may need a ventilator and may not be able to ever come off the ventilator after being put on. If the dog's mentation did not improve in 12 -24 hours, he would likely not recover.

47. According to Dr. Yeamans, Dr. Meredith reached out to her to contact Complainants as they did not seem to fully grasp the severity of the dog's clinical status and she had discussed humane euthanasia with them. Dr. Yeamans reviewed the case and contacted

Complainants. She advised that she had been speaking with Dr. Meredith and they were concerned with the dog's quality of life. Dr. Yeamans also advised that the dog would not be stable to transfer, nor undergo anesthesia for further investigations into his mental state, due to his respiratory compromise. She told Complainants that she was speaking with Dr. Meredith to advise on further care for the dog and options for treatment to help the dog return to a more normal mental status. However, all efforts had not shown significant improvement in the dog's clinical status.

48. Dr. Meredith called Complainants to relay her conversations with Dr. Schnier and Dr. Yeamans. She also advised that the dog had a seizure in the oxygen chamber, which meant the dog had a grave prognosis and was less likely to recover. Dr. Meredith attempted to contact a traveling internal medicine specialist without success. She told Complainants that she was worried the dog would not make the transport to another facility to be evaluated by internal medicine specialist; the dog was oxygen dependent and had another seizure. Dr. Meredith would reach out to their criticalist for a possible consult (she was unavailable until the next day). Complainants were to consider humane euthanasia.

49. According to the medical records, it appeared the dog was getting oral medications.

50. Dr. Deer took over the dog's care. She evaluated the dog – he was obtunded and minimally responsive, similar to when she observed him earlier that morning. Dr. Deer stated that around 7pm, before her evaluation, the dog began to flail and develop nystagmus, lost control of bowel movement and urine. There were concerns of seizure vs another vascular event. At this time, the dog had mild bradycardia and increased respiratory rate and effort.

51. The dog remained obtunded through the night and only became alert for medications. He was uninterested in food or water therefore his medications required to be force fed.

52. On 6/26/20, around 7am, Dr. Deer contacted Complainants with an update. She explained there was no change – the dog was still tachypneic, oxygen dependent, and minimally responsive. There was no interest in food and had to be forcefully medicated orally. Dr. Deer had another discussion with respect to the dog's quality of life, and humane euthanasia. Complainants wanted to have the dog euthanized at home therefore Dr. Deer stated they would continue to treat the dog until they could find an in-home euthanasia service.

53. The dog's care was transferred to Dr. Meredith. Dr. Meredith stated that Complainants called to advise the euthanasia appointment had been scheduled between 1 – 2pm that day therefore she did not follow up with the criticalist. Due to the dog's status, he was unable to take his oral medications therefore none was given and the dog was discharged later that day.

COMMITTEE DISCUSSION:

The Committee discussed that it should not be expected for a veterinarian to be available 24 hours a day – that is why there are emergency services available. The Committee felt that Dr. Schnier was available more than most people would be and his conduct was professionally acceptable.

COMMITTEE'S PROPOSED CONCLUSIONS of LAW:

The Committee concluded that no violations of the Veterinary Practice Act occurred.

COMMITTEE'S RECOMMENDED DISPOSITION:

Motion: It was moved and seconded the Board:

Dismiss this issue with no violation.

Vote: The motion was approved with a vote of 4 to 0.

The information contained in this report was obtained from the case file, which includes the complaint, the respondent's response, any consulting veterinarian or witness input, and any other sources used to gather information for the investigation.

TR

Tracy A. Riendeau, CVT
Investigative Division

ARIZONA STATE VETERINARY MEDICAL EXAMINING BOARD
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10/16/20

COMPLAINT INVESTIGATION FORM

If there is an issue with more than one veterinarian please file a separate Complaint Investigation Form for each veterinarian

PLEASE PRINT OR TYPE

FOR OFFICE USE ONLY

Date Received: Oct. 16, 2020 Case Number: 21-47

A. THIS COMPLAINT IS FILED AGAINST THE FOLLOWING:

Name of Veterinarian/CVT: Dr. Jonathan Schnier

Premise Name: BluePearl Veterinarian Partners - Avondale

Premise Address: 13034 W Rancho Santa Fe Blvd

City: Avondale State: AZ Zip Code: 85392

Telephone: (623) 385-4555

B. INFORMATION REGARDING THE INDIVIDUAL FILING COMPLAINT*:

Name: Frederick Milens and Ashanna Biliter

Address: [redacted]

City: [redacted] State: [redacted] Zip Code: [redacted]

Home Telephone: [redacted] Cell Telephone: _____

**STATE LAW REQUIRES WE HAVE TO DISCLOSE YOUR NAME UNLESS WE CAN SHOW THAT DISCLOSURE WILL RESULT IN SUBSTANTIAL HARM TO YOU, SOMEONE ELSE OR THE PUBLIC PER A.R.S. § 41-1010. IF YOU HAVE REASON TO BELIEVE THAT SUBSTANTIAL HARM WILL RESULT IN DISCLOSURE OF YOUR NAME PLEASE PROVIDE COPIES OF RESTRAINING ORDERS OR OTHER DOCUMENTATION.*

C. **PATIENT INFORMATION (1):**

Name: C[redacted]

Breed/Species: Pomeranian

Age: 14 Sex: M Color: Blonde

PATIENT INFORMATION (2):

Name: _____

Breed/Species: _____

Age: _____ Sex: _____ Color: _____

D. **VETERINARIANS WHO HAVE PROVIDED CARE TO THIS PET FOR THIS ISSUE:**

Please provide the name, address and phone number for each veterinarian.

See attached list of veterinarians.

E. **WITNESS INFORMATION:**

Please provide the name, address and phone number of each witness that has direct knowledge regarding this case.

See list of veterinarians.

Attestation of Person Requesting Investigation

By signing this form, I declare that the information contained herein is true and accurate to the best of my knowledge. Further, I authorize the release of any and all medical records or information necessary to complete the investigation of this case.

Signature: [signature] III

Date: October 11, 2020

Witnesses/Doctors

Dr. Jonathan Schnier
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Dr. Jill Patt
Little Critters Veterinary Hospital
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Gilbert, AZ 85234
(480) 696-7744

COMPLAINT SUMMARY

The Board should find that Dr. Schnier violated A.R.S. § 32-2232 23 as well as violated R3-11-501(1). Dr. Schnier violated 32-2232(23) when although he made assurances that he would be available to assist emergency care providers, he was not available a few hours later. If we knew that Dr. Schnier would not be available to update emergency care providers, we would have sought very different options for his care to try to ensure that C had the best chance at surviving his continuing medical issues.

Dr. Schnier also violated R3-11-501(1) when he failed to show respect for us as C owners, or use professionally acceptable procedures. Again, giving assurances of availability when he then did not attempt to follow through for what appears to be more than a day was very disappointing and unprofessional. Even when we did reach him and conveyed the urgency of the situation, he did not contact the providers until hours later. He further failed to follow up with his recommendations or convey them to us. His opinion was that by performing additional tests on C, we would be able to determine whether it was necessary to euthanize C but he did not convey that opinion to us or follow up with the facility that was caring for C until significantly later.

As a preliminary note, C has long-suffered from seizures and we have been very involved in his care and the different procedures used for his care so that we could give him the best quality of life and best chance of managing his seizures. The following is a summary of the concerns that we have and the history of Dr. Schnier's involvement in C care around the time of C passing.

FACTUAL NARRATIVE UNDERLYING THE COMPLAINT

C suffered two instances of collapse on June 18 and June 19, 2020, leading to hospitalization at 1st Pet Mesa for much of the weekend. The veterinarians there diagnosed anemia and breathing difficulties and suggested the possibility of hemolytic anemia. There were no internal medicine specialists available over the weekend. We proactively made an appointment with Dr. Schnier, C internal medicine specialist, for the following Monday. C had been a patient of Dr. Schnier's since late 2018 when he was practicing at VetMed.

On June 22, 2020, Cody was taken to BluePearl Avondale to see Dr. Schnier. Dr. Schnier ordered a comprehensive set of tests, added some medications, and recommended another checkup on June 24, 2020 to determine whether a transfusion may be necessary.

Dr. Schnier also recommended that we schedule C for a cardiac ultrasound with a cardiologist, and after name-dropping Dr. Schnier at VetMed we were able to obtain an appointment with Dr. Matthews on June 23, 2020. Dr. Matthews examined C and indicated that while C had mild cardiac enlargement and mild pulmonary hypertension, much of which may have been the legacy of C former hypertension and pheochromocytoma, he did not see anything that would be suggestive of a fatal problem.

On June 24, 2020, C had a recheck at BluePearl Avondale. C lab values had worsened and a transfusion was indicated. C occult stool test had come back positive, but

Dr. Schnier indicated that it was likely a false positive as it would not likely account for the level of blood loss required for C[redacted] symptoms; the Coombs test and blood pathology report did not directly indicate IMHA, but the Coombs test could have been a false negative as a result of C[redacted]s continued steroid treatments, and based on Dr. Schnier's conversations it was indicated that IMHA is often a diagnosis of exclusion. Furthermore, Dr. Schnier was able to speak with Dr. Yeamans (who had not returned our message from the prior weekend) and she confirmed that C[redacted]s symptoms were consistent with IMHA and could be the result of reaction to zonisamide. Treatment was commenced for presumptive IMHA with additional medication changes, and C[redacted] remaining zonisamide dose, already cut in half on June 20th, was completely stopped.

C[redacted] was discharged that evening despite earlier expectations of overnight hospitalization as Dr. Schnier felt C[redacted] would do better at home than in a hospital setting. He suggested ARECA and 1st Pet as nearby emergency options. Given C[redacted] complex medical history, I specifically asked if Dr. Schnier would be available to coordinate with them. He indicated in the affirmative, and once C[redacted] was finally discharged some time later, we began the trip back from Avondale to Mesa. C[redacted] seemed quite well on the car ride home.

Within half an hour of returning home, C[redacted] had what initially appeared to be a severe seizure lasting several minutes. My initial concern was the possibility of a rebound seizure or the potential for status epilepticus given the radical reduction in zonisamide dose over the past three days. We administered rectal diazepam and took him directly to 1st Pet Mesa, notifying BluePearl Avondale as discussed just hours prior. We also notified 1st Pet Mesa of his recent history that day and also told them to contact Dr. Schnier at BluePearl Avondale.

Dr. Deer at 1st Pet Mesa expressed concerns regarding C[redacted] at admission, but we informed her that this decline had just happened and his sedateness was likely the result of the diazepam based on our prior experience with the drug. We also informed her that C[redacted] had just been discharged from BluePearl Avondale and that our instructions were to take him to an emergency facility (of which 1st Pet was by far the closest) and coordinate with Dr. Schnier.

Our visit with C[redacted] later that evening also seemed in line with our prior experience considering he had a recent dose of diazepam and was being given intravenous levetiracetam in hospital, and we saw no reason at that time to expect a marked decline in C[redacted] status. Dr. Schnier could not be reached and what was intended as a brief stay intended to stabilize him while seeking further instructions turned into an unintended overnight hospitalization at a facility that turned out to be fundamentally unable to investigate his condition or intervene in any meaningful way. After we left, he declined significantly and Dr. Deer considered it unlikely he would survive even until the morning. Neither Dr. Schnier nor BluePearl responded to us or to 1st Pet Mesa overnight.

On the morning of June 25th we made several more calls to BluePearl Avondale to notify them of the urgency of the situation to no avail. At one point I was able to speak with one of Dr. Schnier's staff, who informed me that Dr. Schnier usually gets up around 8:00 AM, then giggled profusely and went on to state not to ask her *how* she knew that, but that she knew that; the

exchange did not inspire confidence regarding the continued professionalism of the staff or the facility under such dire circumstances.

At midmorning I was finally able to speak with Dr. Schnier directly and informed him of the dire prognosis from 1st Pet Mesa. He indicated that he reviewed the records from 1st Pet Mesa and indicated to me that it did not seem that concerning as of yet. I stated that this was quite different from what I had been told from 1st Pet Mesa and asked him to call directly given their prognosis. He indicated that he was very busy with appointments but would attempt to do so later in the day. I also asked if it would be better to transfer him to BluePearl Avondale so that he could be observed there instead, and he responded that there would be no benefit to having C[redacted] seen at BluePearl at that time. We subsequently visited C[redacted] at 1st Pet Mesa and concurred with their evaluation that he had declined significantly since our visit the night before as C[redacted] now seemed basically nonresponsive to our presence or touch.

BluePearl's records indicate that Dr. Schnier was finally able to speak with Dr. Meredith at 1st Pet Mesa. Based on 1st Pet Mesa and BluePearl records the eventual conversation between Dr. Schnier and Dr. Meredith at 1st Pet Mesa occurred no earlier than mid-afternoon on June 25, an interval of approximately 18 hours since we first notified BluePearl of C[redacted] post-discharge issue the night before. While providing a very guarded assessment of C[redacted]'s condition, he nonetheless suggested possible options for investigation prior to euthansia. None of these were passed along to us by Dr. Meredith and Dr. Schnier never followed up with us directly with these suggestions. 1st Pet Mesa, unfortunately, has no details of these conversations in the records provided to me.

Based on strongly pro-euthanasia advice from Dr. Yeamans and Dr. Meredith, and no information to suggest otherwise from Dr. Schnier's office, we arranged for home euthanasia for C[redacted] He died at approximately 1:30 PM on June 26, 2020. Dr. Schnier did not speak to us directly until the following week when he had learned of C[redacted] euthanasia and called to express his condolences. We also received flowers from BluePearl.

Jonathan Schnier,
BluePearl Specialty and Emergency Pet Hospital
13034 West Rancho Santa Fe,
Avondale, Arizona,

November 1, 2020

Arizona State Veterinary Medical Examining Board
1740 W. Adams St., STE 4600,
Phoenix, Arizona 85007

Narrative Account Re: 21-47 for Patient C[redacted] Milens
I am writing in response to your letter dated October 20, 2020 with respect to a complaint that has been filed against me by Frederick Milens and Ashanna Biliter regarding their pet, C[redacted]

I had worked with C[redacted] and Mr. Milens since the fall of 2018 (as a small animal internal medicine specialist). At that time, C[redacted] was evaluated at VETMED where he was ultimately diagnosed with a pheochromocytoma involving his left adrenal gland. The pheochromocytoma was resected by a surgeon at UC Davis in December 2018. I had continued to work with C[redacted] and his owners since that time and I have re-evaluated him numerous times at VETMED and later at BluePearl.

Most pet owners would not go to the lengths that Mr. Milens had done for the sake of a pet. I would like to again provide Mr. Milens and Ashanna Biliter with my condolences regarding the loss of C[redacted] Mr. Milens narrative of the events prior to C[redacted] euthanasia are similar to those included in my narrative with some exceptions. When Mr. Milens' narrative is reviewed, it is readily apparent that I have not violated any statutes with respect to my professional conduct. To the contrary, the factual information presented by Mr. Milens in his statement indicates that I went above and beyond my professional requirements in C[redacted] case. Mr. Milens complaints related to my actions are misguided and his expectations were impractical in nature. Because of this, I would request that the board dismiss Mr. Milens' complaint with no violation.
At the time of C[redacted] last examination at BluePearl on June 24th, 2020, C[redacted] problem list included the following:

1. Hind limb neuropathy/myopathy, diagnosed on 08/02/2019
2. Pheochromocytoma (left-adrenal) (Removed at UC Davis in 12/2018)
3. Tracheal collapse at level of mainstem bronchus and Intrathoracic
4. Spondylosis deformans multilevel - cervical - severe, LS - mild
5. Hydrocephalus - congenital COMS
6. Bilateral medial patellar Luxation
7. Previous right forelimb trauma with resultant valgus deformity
8. History of seizures with recent onset of grand mal and focal seizures
9. Intermittent hyponatremia/hypochloremia/hyperkalemia
10. Hypothyroidism
11. Proteinuria (mild to moderate)
12. Cortical blindness OD
13. History of hypertension
14. Recent onset of lethargy, intermittent collapse, and vomiting
15. Elevated Spec cPL consistent with pancreatitis
16. Recent onset of severe non-regenerative anemia - Currently regenerative
17. Leukocytosis with a mild left shift
18. Moderate pulmonary hypertension with left ventricular hypertrophy and mitral valvular insufficiency (mild)
19. Generalized poor lung inflation
20. Fecal occult blood positive

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C[redacted] had been examined by me at BluePearl on 10 separate dates between August 13, 2019 and June 24th, 2020. He was last evaluated by me on June 24th, 2020. He was never hospitalized overnight at BluePearl Avondale during this time period.

C[redacted] had also been evaluated by multiple other veterinary facilities during this timeframe, including Animal Medical and Surgical Center (AMSC)/The Animal Neurology and Imaging Center (ANIC), the Veterinary Neurological Center (VNC), 1st Pet Veterinary Center (Mesa and Chandler), VetMed, and Little Critters Veterinary Hospital. Mr. Milens was also in contact with a staff neurologist at UC Davis' Veterinary Hospital. C[redacted] had been hospitalized for treatment/monitoring of seizures with AMSC/ANIC and 1st Pet multiple times over this period of time. According to records provided by 1st Pet, C[redacted] was evaluated/treated at 1st Pet Veterinary Center on 27 dates from November 1st 2019 through June 25th 2020. In the month of June, 2020, C[redacted] was evaluated at 1st Pet on June 3rd, June 5th, June 9th, June 11th, June 16th, June 21st, June 24th, and June 25th.

C[redacted] presented for a recheck examination at BluePearl on June 22nd (Monday). C[redacted] had not been evaluated by myself or BluePearl since April 22nd, 2020 at that time. Prior to June 22nd, my last contact with Mr. Milens was on April 23rd, 2020 at which time we discussed lab work results from C[redacted]'s April 22nd visit.

BluePearl's records indicate that Mr. Milens called BluePearl on Sunday June 21st, 2002. The following conversation was documented by Jazzmine Ledesma, an ER veterinary technician:

> Owner called stating that the patient was being seen at the 1st pet in mesa. Owner stated that he was wondering if Dr. Schnier could call and discuss the patient with 1st pet. I informed her that unfortunately Dr. Schnier is not "on-call" that I would text him and let him know however the issues that C[redacted] presented for at first pet are newer issues so Dr. Schnier would not likely be able to provide any information other than a history. I told him that I would call 1st pet and talk with them.
>
> Called 1st pet and spoke with Dr. Deer and told her unfortunately Dr. Schnier is not on call all the time and that I would text him to let him know. Dr. Deer informed me that C[redacted] presented a few days ago and they recommended that they follow up with internal medicine and it was not done. They have an appointment scheduled for Monday. Dr. Deer stated that the owners are having difficulty understanding that it might be time. Thanked her for her time and I would pass along the message.

On Monday June 22nd, C[redacted] owners reported that he had been feeling well as recently as the morning of June 18th. On the afternoon of June 18th, an episode of collapse associated with a brief period of apnea was noted. This resolved quickly and no seizure activity was noted. On June 19th at ~ 4 PM C[redacted] vocalized and then collapsed. A 20-30s period of apnea was noted. He was evaluated at 1st Pet following this episode. Severe anemia was reported with a hematocrit of 21%. C[redacted] anemia was non-regenerative at that time. Possible RBC clumping was reported on a slide-agglutination test and spherocytes were suspected on in-hospital evaluation of C[redacted] blood sample; however, a CBC performed with Idexx on June 20th with 1st Pet demonstrated no evidence of spherocytes or auto-agglutination.

Radiographs were performed and demonstrated the following:

> Hepatomegaly. Abnormal gastric contents. Unusual food or foreign material could be considered. Degenerative changes of the cervical and thoracolumbar spine. Suspect collapse of the bronchus to the right cranial lung lobe. Much of the increased interstitial opacity is likely due to poor inflation of the lung. A concurrent infiltrate or edema cannot be entirely excluded.

C[redacted] was hospitalized with 1st Pet. He was treated with IV fluids and antibiotics. He did not receive a blood transfusion and his PCV had improved to 22% on June 21st. C[redacted] was discharged from the hospital on June 21st. He walked outside to urinate later that evening and experienced another episode of collapse associated with a short period of apnea. C[redacted] had not been able to walk very well, and he has not had not passed a bowel movement over the previous several days. No signs of melena had been noted. At that time, C[redacted] was receiving imepitoin (100 mg PO q12h), levetiracetam (250 mg, 1.25 tablets PO q8h), zonisamide (25 mg PO q24h), prednisone (1 mg PO q12h), omeprazole (20 mg PO q12h), levothyroxine (100 mcg in the AM, 50 mcg in the PM), telmisartan (10 mg/ml, 0.2 ml PO q24h), amlodipine (2.5 mg, 1/2 tab PO q24h), Flovent HFA (110 mcg/actuation, 1 actuation q12h), Denamarin Advanced (1/4 tab once daily), and Clavacillin (62.5 mg PO q12h). Hydrocodone/homatropine (5 mg/1.5 mg, 1/2 tab PO up to q12h PRN), Entyce (0.4 ml once daily), and diazepam rectal gel (10 mg during/after seizure) administered intermittently, as needed.

C[redacted] may have experienced a mild (~ 30 s) seizure following one of his episodes of collapse over the weekend (June 20th-21st). His previous seizure was noted in May. His last cluster seizure occurred in March. His owners report that he had been experiencing seizures ~ every 5-6 weeks.

On examination at BluePearl on June 22nd, C[redacted] was quiet and somewhat subdued yet responsive. He had a body condition score of 4/9. C[redacted] was unable to walk in the hospital and he demonstrated difficulty standing. Carpal valgus was noted, most prominent in the right forelimb. The hind limbs were contracted forward. There was no ocular, aural or nasal discharge. Mucous membranes were pale pink and moist with a CRT<2s. There was marked dental calculus. Peripheral lymph nodes palpated within normal limits. A soft grade II/VI left systolic murmur was suspected on auscultation with a sinus arrhythmia. Fair and synchronous pulses were present. The lungs ausculted clear in all fields although intermittent episodes of panting and tachypnea were noted with increased respiratory effort noted at times. No pain, or masses were palpable in the abdomen. C[redacted] skin and hair coat were unremarkable. Formed brown stool was noted on rectal examination.

The following diagnostics were performed at BluePearl on June 22nd:

- Blood Pressure: 79 mm Hg.
- Thoracic/Abdominal Radiographs:
  Findings:
  Four current images that include thorax and abdomen are available. These images are compared to images dated 1/7/2020.
  There is poor inflation of the lung exacerbating the appearance of cardiac size. The cardiovascular structures are subjectively normal for size and shape. Right cranial lung is small and alveolar pattern is noted silhouetting with the adjacent heart. The trachea is mildly undulating in contour. There is a mild diffuse interstitial and bronchial pattern. Spondylosis deformans is considered incidental. Numerous cervical and thoracolumbar intervertebral disc spaces are narrowed. Small osteophytes are present in the elbows. The liver is persistently mildly enlarged. No definitive splenic, renal or gastrointestinal abnormality is seen. The urinary bladder is large. Right patella is luxated.
  Assessment:
  Generalized poor lung inflation consistent with recumbency and may be exacerbated by concurrent tracheal collapse. Associated right cranial atelectasis. Concurrent mild diffuse tracheobronchitis and mild right cranial pneumonia are possible.
  Otherwise normal thorax. Echocardiography with ECG can be helpful to screen for occult cardiac disease.
  Nonspecific hepatopathy can be associated with any infiltrative process, such as vacuolar hepatopathy, cholangiohepatitis or infiltrative neoplasia. If indicated, ultrasonography and histopathology/cytology can be helpful.
  Elbow arthritis. Patella luxation.
  Multifocal cervical and thoracolumbar IVDD.

- Abdominal Ultrasound:
  - Liver: Mild to moderate hepatomegaly was noted with diffusely hyperechoic parenchyma (mild).
  - Gallbladder & Common Bile Duct: Normal wall thickness; The gall bladder measured 2.26 x 2.40 cm. The gall bladder lumen contained a moderate to large volume of sludge. No evidence of biliary duct distension was noted.
  - Left Kidney: Reduced in size; 3.13 cm in length. Moderately irregular margins were noted with hyperechoic parenchyma and moderate loss of corticomedullary distinction.
  - Right Kidney: Reduced in size; 3.03 cm in length. Moderately irregular margins were noted with hyperechoic parenchyma and moderate loss of corticomedullary distinction.
  - Left Adrenal: Previously resected.
  - Right Adrenal: 0.46 cm in diameter.
  - Spleen: Normal size and echogenicity; Two small non-deforming hypoechoic nodules were noted, measuring up to 0.28 cm in diameter. The splenic nodules appear most consistent with a benign process such as lymphoid hyperplasia and/or extramedullary hematopoiesis.
  - Pancreas: The right pancreatic limb measured 0.47 cm thick.
  - Gastrointestinal: Normal bowel wall thickness and layering; No gastric or colonic abnormalities were noted.
  - Intra-abdominal Lymph Nodes: No significant lymph node enlargement was noted
  - Bladder: Normal wall thickness; normal content echogenicity;
  - Prostate: 0.61 cm in diameter.
  - Peritoneum: No peritoneal effusion was noted.
  - Mesentery: No abnormalities noted
  - Comments: (Abnormal findings are listed in bold print)

  Conclusions:
  - Mild to moderate hepatomegaly was noted with hyperechoic parenchyma (mild). The hepatic changes are suspected to represent a vacuolar hepatopathy. This may be associated with chronic prednisone administration or possibly, underlying endocrine/metabolic disease.
  - Bilateral renal changes were noted, consistent with chronic kidney disease. Renal size appears to be stable when compared to previous ultrasound studies.
  - Two small non-deforming hypoechoic nodules were noted, measuring up to 0.28 cm in diameter. The splenic nodules appear most consistent with a benign process such as lymphoid hyperplasia and/or extramedullary hematopoiesis.
  - The left adrenal gland was previously removed (pheochromocytoma). No evidence of neoplasia or metastasis was detected on the current abdominal ultrasound study.
  - No peritoneal effusion was noted. No abnormalities were noted to account for the patient's signs of anemia. Primary differentials include gastrointestinal blood loss (associated with gastrointestinal ulceration) vs hemolytic anemia.

- Snap 4Dx: Negative.
- PT/PTT:

Date/Time	Test	Result	Reference Range
6/22/2020	cit-aPTT	= 68.0 seconds (L)	72.0 - 102.0
6/22/2020	cit-PT	= 11.0 seconds	11.0 - 17.0

- Venous Blood Gas Panel with PCV/TS:

Date/Time	Test	Result	Reference Range
6/22/2020	PH	= 7.157 35.2 (L)	7.34 - 7.42
6/22/2020	PCO2	= 23.6 mmHg (L)	24.4 - 39.3
6/22/2020	PO2	= 72.3 mmHg (H)	30.6 - 57.4
6/22/2020	SO2	= 87 %	50.4 - 89.2
6/22/2020	HB	= 6.4 g/dl (L)	13.3 - 20.5

6/22/2020 NA+ = 147 mmol/L 145 - 152
6/22/2020 K+ = 5.6 mmol/L (H) 3 - 4.8
6/22/2020 CL- = 123 mmol/L 113 - 124
6/22/2020 CA++ = 1.37 mmol/L 1.25 - 1.5
6/22/2020 MG++ = 0.60 mmol/L 0.43 - 0.6
6/22/2020 GLU = 159 mg/dl (H) 66 - 115
6/22/2020 LAC = 3.0 mmol/L 0.3 - 3.4
6/22/2020 BUN = 63 mg/dl (H) 11 - 31
6/22/2020 CREAT = 0.8 mg/dl 0.7 - 1.8
6/22/2020 GAP = 21.9 mmol/L (H) 11 - 21
6/22/2020 BE-B = -17.9 mmol/L
6/22/2020 HCO3- = 8.4 mmol/L (L) 16 - 24
6/22/2020 OSM = 315 mOsm/kg (H) 290 - 300
6/22/2020 PCV = 23 % buffy coat - 0.05%
6/22/2020 TP = 8.0 g/dl serum: - clear

- ECG Rhythm Strip: Changes consistent with a sinus arrhythmia were noted. No VPCs were detected.
- Fecal Occult Blood Test (Antech): Positive.
- Comprehensive CBC (Idexx): Hct – 17.8%, Retic – 153 K, WBC – 19.1 K, Neut – 16.617 K, Bands – 573, Lymph – 0.191 K, Mono – 1.719 K, Plt – 400 K. Neutrophils appeared slightly toxic.
- Chemistry Panel (Idexx): Glu – 130, SDMA – 19, BUN – 72, Phos – 7.7, K – 5.9, Na:K – 25, TCO2 – 12, Alb – 2.6, Glob – 3.4, ALT – 130, ALP – 1353, GGT – 55, Trig – 604, Lipase>1800.
- Total T4 (Idexx):1.7
- Cardiopet NT-proBNP: Markedly elevated at 2407 pmol/L.
- Urinalysis with Reflex UPC: 1.5
- Anemia PCR Panel: Negative.
- Coomb's Test (Idexx): Negative.

Please refer to attached Idexx lab reports for details.

On June 22nd, the following treatments were administered in hospital:

- Iron Dextran (200 mg/ml) - 0.35 ml IM.
- Cobalamin (1000 mcg/ml) - 1 ml SC.
- Lactated Ringers Solution - 150 ml SC
- Oxygen Kennel - C[redacted] was maintained in an oxygen kennel for several hours during the day in between diagnostic tests/blood draws. C[redacted] was able to rest with a normal respiratory rate and no significant increase in respiratory effort when he was calm. Three-episodes of vomiting were noted throughout the day (bile-tinged fluid).

Options for hospitalization and packed red blood cell (RBC) transfusion were discussed. C[redacted] owners noted that they would like to avoid a transfusion at that time; however, they scheduled a follow-up appointment to have C[redacted] PCV/TS rechecked with BluePearl on the morning of June 24th. It was discussed that a blood transfusion may be administered at that time, if clinically warranted.

C[redacted] owners were discharged with instructions to monitor for signs of inappetence, vomiting, diarrhea, lethargy, abdominal pain, recurrent seizures, collapse, pale/white mucous membranes, progressive vision loss and/or respiratory distress.

C[redacted] was discharged with a medication table including directions to continue the following medications: Entyce, Cerenia, omeprazole, prednisone, sucralfate, Clavacillin, Orbax, Sildenafil, Denamarin Advanced, Hydrocodone, Levothyroxine, levetiracetam, imepitoin, zonisamide, mirtazapine, and a fluticasone inhaler. C[redacted] owners were advised to discontinue telmisartan and amlodipine. It was recommended that C[redacted] receive a low-fat diet.

We discussed the following (included in a typed report provided to C[redacted] owners on June 22nd):

C[redacted] liver enzymes have improved when compared to previous lab work performed in April (likely due to discontinuing phenobarbital). His total bilirubin levels have remained normal. The liver enzyme elevations are likely associated with prednisone and phenobarbital administration. The significant serum bile acid elevation noted on C[redacted] previous lab work is concerning for significant hepatic dysfunction. Bile acids should be re-assessed ~ 1 month after discontinuing phenobarbital. C[redacted] renal values have remained normal. C[redacted] fasted triglyceride levels were moderately elevated. An elevated lipase level was noted. This may be associated with pancreatitis; however, no ultrasonographic evidence of acute pancreatitis was noted. Elevated BUN and phosphorous levels were noted. These values may have risen secondary to C[redacted] renal disease; however, similar changes may occur with gastrointestinal bleeding. C[redacted] SDMA levels were mildly elevated. His albumin levels were slightly decreased although relatively mild proteinuria was noted.
C[redacted] current CBC has demonstrated moderately to markedly severe regenerative anemia. No evidence of hyperbilirubinemia, spherocytes, and/or auto-agglutination was noted to support hemolytic anemia; however, this possibility cannot be entirely excluded. No source for C[redacted] blood loss was noted and his clotting times were essentially normal. He is likely anemic secondary to hemolysis or possibly, occult gastrointestinal bleeding. A Coombs' test is pending for further evaluation of immune-mediated hemolytic anemia (IMHA) along with a PCR panel testing for infectious diseases associated with anemia. A fecal test to identify occult blood is also pending.
C[redacted]s current PCV has remained stable and his hematocrit has dropped only slightly from June 20th. Progressive anemia is typical for IMHA. A blood transfusion is likely warranted if C[redacted]s anemia fails to improve within the next 24-48 hours. Empirical treatment for IMHA may be considered if another source of anemia is not identified.
C[redacted]s blood pressure was slightly low today. His anti-hypertensive medications should be discontinued with evidence of hypotension and recent signs of collapse. Sildenafil has been prescribed as empirical treatment for pulmonary hypertension. An echocardiogram with a cardiologist has been recommended. Sildenafil may be continued long-term if significant pulmonary hypertension is confirmed via echocardiogram.
We will contact you with C[redacted] pending laboratory results as they become available. A follow-up technician appointment has been scheduled for the morning of June 24th. A follow-up PCV/TS, CBC, and blood pressure should be performed at that time. A blood transfusion may be warranted if progressive anemia is noted. C[redacted] may be re-evaluated at an earlier date if he is not feeling well.

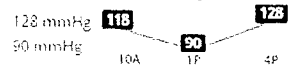
C[redacted] presented for a recheck examination at BluePearl on June 24th. C[redacted] had been feeling relatively well since his previous examination on June 22nd. He was evaluated with Dr. Matthews (cardiologist) on June 23rd. An echocardiogram performed at that time demonstrated left ventricular hypertrophy, mild mitral valve insufficiency, and moderate pulmonary hypertension. C[redacted]s CBC performed on June 22nd demonstrated mild progression of his anemia (Hct - 17.8%) with evidence of regeneration. A mild leukocytosis was noted with a mild left shift. No spherocytes were noted and a Coombs test was negative. Total bilirubin levels were low-normal and no evidence of bilirubinuria was noted. A SNAP 4Dx test was negative. An anemia PCR panel is pending. A fecal occult blood test was positive. C[redacted]s NT-proBNP levels were significantly elevated (2407 pmol/L).

On examination at BluePearl, on June 24th, C[redacted] was quiet and somewhat subdued yet responsive. He had a body condition score of 4/9. C[redacted] was unable to walk in the hospital and he demonstrated difficulty standing. Carpal valgus was noted, most prominent in the right forelimb. The hind limbs were contracted forward. There was no ocular, aural or nasal discharge. Mucous membranes were pale pink and moist with a CRT<2s. There was marked dental calculus. Peripheral lymph nodes palpated within normal limits. A soft grade II/VI left systolic murmur was suspected on auscultation with a sinus arrhythmia. Fair and synchronous pulses were present. The lungs ausculted clear in all fields although intermittent episodes of

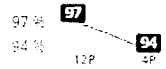
panting and tachypnea were noted with increased respiratory effort noted at times. No pain, or masses were palpable in the abdomen. C[redacted] skin and hair coat were unremarkable.

The following diagnostics were performed at BluePearl on June 24th:

- Blood Pressure (systolic, Doppler):



- Oxygen Saturation (SpO2%)



- Crossmatch Kit (Rapidvet-H): Compatible with single unit of DEA 1.1 Negative pRBCs.
- ECG Monitoring: A sinus arrythmia was noted with no evidence of a pathologic arrythmia or VPCs.
- CBC with Pathologist Review: (Idexx)

Date/Time	Test	Result	Reference Range
6/24/2020	ANISO	MODERATE	
6/24/2020	BASO	0.0 %	
6/24/2020	EOS	0.0 %	
6/24/2020	HCT	14.9 % (L)	38.3 - 56.5
6/24/2020	HGB	4.6 g/dL (L)	13.4 - 20.7
6/24/2020	LYMPHS	3.0 %	
6/24/2020	MCH	25.3 pg	21.9 - 26.1
6/24/2020	MCHC	30.9 g/dL (L)	32.6 - 39.2
6/24/2020	MCV	82 fL (H)	59 - 76
6/24/2020	MONOS	14.0 %	
6/24/2020	NEUT BANDS	3.0 %	
6/24/2020	NEUT SEG	80.0 %	
6/24/2020	NRBC	4 per 100wbc (H)	0 - 2
6/24/2020	PLATELETS	268 K/uL	143 - 448
6/24/2020	POLY	MODERATE	
6/24/2020	RBC	1.82 M/uL (L)	5.39 - 8.70
6/24/2020	RETIC CNT	10.4 %	
6/24/2020	WBC	25.0 K/uL (H)	4.9 - 17.6
6/24/2020	ABS BASO	0 /uL	0 - 100
6/24/2020	ABS EOS	0 /uL (L)	70 - 1490
6/24/2020	ABS LYMPHS	750 /uL (L)	1060 - 4950
6/24/2020	ABS MONOS	3500 /uL (H)	130 - 1150
6/24/2020	ABS NEUTB	750 /uL (H)	0 - 170
6/24/2020	ABS NEUTS	20000 /uL (H)	2940 - 12670
6/24/2020	ABS RET	189 K/uL (H)	10 - 110
6/24/2020	RETIC-HGB	26.9 pg	22.3 - 29.6

REMARKS
WBC corrected for the presence of nucleated RBC's
Slight Howell Jolly Bodies
Neutrophils appear slightly toxic.
Dohle bodies seen.
Slide reviewed microscopically.
Results preliminary pending pathologist review.

- PCV/TS:

10:00

Date/Time	Test	Result	Reference Range
6/24/2020	PCV	= 17 % (L)	37 - 50
6/24/2020	TS	= 6.2 g/dL	4.8 - 7.6

18:45 (1 hour post-transfusion)

Date/Time	Test	Result	Reference Range
6/24/2020	PCV	= 46 %	37 - 50
6/24/2020	TS	= 6.8 g/dL	4.8 - 7.6

I discussed C[redacted]s lab results with his owners on June 24th. A blood transfusion was recommended as C[redacted]anemia had progressed from June 22nd. We discussed that C[redacted]would receive a blood transfusion in hospital with close monitoring and that he could be discharged from the hospital following the blood transfusion if he did not experience any complications. Overnight hospitalization was not considered to be necessary unless C[redacted]experienced complications.

The following treatments were performed at BluePearl on June 24th:

- An IV catheter was placed. C[redacted]was hospitalized throughout the day and received the following treatments:
- Blood, K9 PRBCS 1.1 neg single unit | 1 ea | q1h | 85 ml total administered via syringe pump. Use aseptic technique to draw blood from bag. Start at 4 ml/h for 15 minutes then increase to 8 ml/h for 15 minutes then increase to 16 ml/h until finished (if tolerated). | completed on 06/24/2020 5:45 PM
- Sucralfate (Carafate)100mg/mlSusp(perml) | 58.8mg/kg, 200mg | PO | q8h | last dose 06/24/2020 18:00 P
- Levetiracetam (Keppra) 250 mg Tablet | 91.9mg/kg, 313mg | PO | q8h | last dose 06/24/2020 02:00P
- Denamarin 225mg Tablet BV | 16.5mg/kg, 56.2mg | PO | q24h | last dose 06/24/2020 02:00P
- Orbax 30mg/ml Oral Susp (per ml) | 5.29mg/kg, 18mg | PO | q24h | last dose 06/24/2020 01:01P
- Dexamethasone SP(Dexium)4mg/mlInj(perml) | 0.29mg/kg, 1mg | IV | q24h | last dose 06/24/2020 11:30A
- Cyclosporine (Atopica) 10mg Capsule | 2.94mg/kg, 10mg | PO | q12h | last dose 06/24/2020 01:06P
- Clopidogrel (Plavix) 75 mg Tablet | 2.76mg/kg, 9.38mg | PO | q24h | 1/8th of a tab | last dose 06/24/2020 01:06P
- Cody was discharged from the hospital at ~ 8 PM on June 24th.

Prior to the time of discharge, I reminded C[redacted]s owners that our hospital (BluePearl Avondale) was open and staffed 24 hours per day with veterinary technicians and veterinarians. Mr. Milens was instructed to call at any time with questions or concerns. It was both noted and implied that Mr. Milens would speak with the ER department staff if the call was outside of 'normal' business hours. There was no statement made to indicate or imply that I would personally be in the hospital or available 24 hours per day to speak with C[redacted]owners directly. However, I can typically be contacted by BluePearl's staff 24/7 by telephone and it is not uncommon for the staff at BluePearl to call or text me outside of my normal hours, if necessary.

The following information was discussed with C[redacted]owners and included in a typed report provided at the time of discharge:

> C[redacted], current CBC has demonstrated evidence of severe, progressive, regenerative anemia. C[redacted]received a blood transfusion today, which appears to have been tolerated very well. We contacted Dr. Yeamans (neurologist) and she noted that Zonisamide could have possibly triggered C[redacted]anemia. She agreed that it would be reasonably safe to discontinue zonisamide at this time; however, treatment with phenobarbital may need to be re-started if recurrent seizure activity is noted. C[redacted] fecal occult blood test was positive, indicating a possibility of gastrointestinal bleeding; however, melena and gastrointestinal signs would be expected with C[redacted]urrent level of anemia if GI bleeding was responsible for his signs.
> We will contact you with C[redacted]pending laboratory results as they become available. A follow-up technician appointment is recommended for the morning of June 26th. A follow-up PCV/TS and blood pressure should be performed at that time. A follow-up examination and lab work (CBC/chemistry panel) and blood pressure is

recommended in ~ 1 week. C[redacted] should be re-evaluated at an earlier date if he is not feeling well.

C[redacted] owners were instructed with the following directions, also included in his discharge paperwork: Please monitor for signs of inappetence, vomiting, diarrhea, lethargy, abdominal pain, recurrent seizures, collapse, pale/white mucous membranes, progressive vision loss and/or respiratory distress. Contact a veterinarian if any of these signs are noted.

C[redacted] discharge paperwork also included the following medication table. Recent changes to his medications were highlighted with bold type font and discussed with his owners.

MEDICATION	STRENGTH	USE	DOSE	ROUTE	FREQUENCY
Entyce	30 mg/ml	Appetite Stimulant	0.35 ml	orally	every 24 hours if needed for signs of inappetence
Cerenia	16 mg	Anti-Nausea	1/2 tab	orally	Every 24 hours if needed for nausea/vomiting. Next dosage is due tomorrow afternoon.
Omeprazole	20 mg	antacid	1 tablet	orally	Every 12 hours as directed by Cody's neurologist
Atopica	10 mg	Immunomodulating Agent	1 capsule	orally	Every 12 hours. Next dosage is due tonight.
Sucralfate	100 mg/ml	GI Protective	2 ml	orally	Administer every 8 hours for 10 days. Do not give within 2 hours of other oral medications or food.
Clavacillin	62.5 mg	Antibiotic	1 tablet	orally	Continue as directed by the prescribing veterinarian (1 tab every 12 hours). Discontinue if signs of nausea/vomiting persist.
Orbax	30 mg/ml	Antibiotic	0.8ml	orally	Administer once daily with food. Continue until time of recheck examination and then as directed.
Sildenafil	**20 mg**	**pulmonary hypertension**	**1/4 tablet**	**orally**	**Every 12 hours. Increase dosage to 1/2 tablet every 12 hours in 5 days time (June 29th).**
Denamarin Advanced	225 mg	liver support	1/4 tablet	orally	every 24 hours
Heartgard Plus		heartworm preventative		orally	every 30 days
Hydrocodone	5 mg	cough suppressant	1/2 tablet	orally	Up to every 6 hours as needed for cough
Levothyroxine	0.1mg	Thyroid Medication	Increase dosage to 1 tablet in the AM and 1/2 tablet in the PM	orally	Administer every 12 hours
Levetiracetam	250mg	Anticonvulsant	1 and 1/4 tablet	orally	Every 8 hours or 1.25 tabs following a seizure

Imepitoin	100 mg	Anticonvulsant	1 caplet	orally	Every 12 hours (dosage increased on March 30th)
Prednisolone	**3 mg/ml**	**Corticosteroid**	**1.2 ml**	**orally**	**Every 12 hours. Start tonight (June 24th) in place of prednisone.**
Mirtazapine	**7.5 mg**	**Appetite Stimulant**	**1/4 tablet**	**orally**	**Once daily if needed for appetite stimulation**
Fluticasone Inhaler	110 mcg	Steroid Inhaler	1 puff	via the inhalant chamber	1 puff every 12 hours.
Clopidogrel	**5 mg**	**Anti-Platelet Drug**	**1 capsule**	**by mouth**	**Once daily. Rx to Red Mountain Compounding, Mesa AZ. Start**
Discontinue for Now					
Prednisone	**1 mg**	**steroid**	**1 tablet**	**orally**	**Currently giving 1 tablet TWICE daily**
Zonisamide	**25 mg**	**Anticonvulsant**	**1 capsule**	**orally**	**Every 24 hours**
Telmisartan	10mg/ml	blood pressure	0.2ml	orally	every 24 hours as directed by Cody's family veterinarian
Amlodipine	2.5mg	blood pressure	1/2 tablet	orally	every 24 hours

DIET
A low-fat diet may be helpful to reduce C[redacted] triglyceride levels and to reduce his risk for recurrent pancreatitis. A home-made diet may be formulated by a veterinary nutritionist to help address C[redacted] elevated triglyceride levels and chronic kidney disease. Cornell's nutrition service will work directly with pet owners to formulate a balanced, appropriate diet.

On June 25th, I arrived at BluePearl's Avondale location at ~ 9 AM to see scheduled appointments. My schedule was full for the morning and my first appointment was scheduled for 9 AM.

I was provided with the following message regarding C[redacted] from our reception desk:

Date: 6/25/2020
Time: 08:49
Staff: BMM
Owner Frederick Milens
828-545-1182
Attention: Dr. Schnier
Owner called early this morning wanting to talk with Dr. Schnier as C[redacted] vas in 1st Pet Vet. in very critical condition. Staff did not know how to contact Dr. Schnier. Message was given to Dr. Barnard when she came in.

Erika took message and gave me the information.
Bert

Although the receptionist's message indicates that the staff did not know how to contact me, this is not the case. The staff at all of the 4 BluePearl Arizona locations have access to my cell phone number and email. I am regularly contacted by BluePearl staff multiple times per week outside of 'normal' business hours. I frequently come in to work on nights and weekends for emergency after-hours procedures. However, our facility is staffed 24 hours a day with veterinarians and technicians and I would expect that the staff on shift would address concerns from an owner or referring veterinarian when I am not in the hospital. If the staff is unable to address these concerns, they will typically contact me at any time (if warranted) to discuss the situation. In C[redacted] case, the staff likely deemed that it was inappropriate to contact me at home as the pet was not hospitalized at BluePearl and the pet was receiving veterinary

care at another facility. It appears that the staff at 1st Pet did not require or request my input and that they had contacted me primarily to appease Mr. Milens. I am not certain as to what Mr. Milens expected me to do in order to intervene with C[redacted] care at another veterinary facility. I feel that it is unprofessional and possibly, detrimental for me to direct the care of a patient whom I cannot physically evaluate that is not actively under my care.

I spoke with Mr. Milens in the morning on June 25th once I arrived at work. He reported that C[redacted] was hospitalized at 1st Pet overnight. He noted that he was told that C[redacted] was severely hypotensive and had low oxygen saturation. I discussed that I had reviewed the records from 1st Pet. C[redacted] initial blood pressure was low; however, a normal measurement was obtained following IV fluids and normal blood pressures were reported later in the morning. A normal oxygen saturation reading (SPO2%) was reported on admission (98% on room air). Mr. Milens requested that I speak with the doctors at 1st pet to obtain an update. Mr. Milens asked if we should arrange to have C[redacted] transferred from 1st Pet to BluePearl. I noted that this may not be in C[redacted] best interest if he was not stable and that 1st Pet should be able to provide the same level of care and treatments that BluePearl could provide. I noted repeat advanced imaging of C[redacted] head +/- thoracic cavity could potentially provide additional information although advanced imaging (CT/MRI) was not available at BluePearl's Avondale location. Re-evaluation with ANIC may be helpful although C[redacted] would need to be stabilized prior to considering an MRI or CT scan.

A message was left with me to return a call from Dr. Meredith at 1st Pet (documentation of this message was time stamped at 12:46 PM on June 22nd). I called 1st Pet to speak with her shortly after receiving the message. She reported that C[redacted] SPO2 had been low despite treatment with oxygen and that his respiratory rate with oxygen saturation was ~ 30. I noted that this is concerning; however, an SPO2 of 98% on room air was reported on entry at 1st pet. I noted that the oxygen saturation readings may not be accurate; however, Dr. Meredith reports that C[redacted] respiratory rate was elevated outside of oxygen. I noted concern for pulmonary thromboembolic disease or possibly, aspiration pneumonia. I suggested that repeat thoracic radiographs may be helpful. Dr. Meredith noted that she would consider this. She also reported that C[redacted] had remained obtunded although he was able to take oral medications. I noted that this could be related to post-ictal event associated with seizures and anticonvulsant treatments; however, I am concerned regarding a stroke-like event. I discussed that a CT or MRI could be considered for further evaluation, if possible. Dr. Meredith noted concerns related to C[redacted] quality of life. I discussed that I shared her concerns. I noted that options for C[redacted] at that time appear to be continued treatment/hospitalization +/- advanced imaging vs euthanasia. I noted that if there was a concern for pulmonary thromboembolism or ischemic stroke, treatment with enoxaparin may be added in addition to clopidogrel. Dr. Meredith noted that she would plan to keep us updated and she noted that she will update C[redacted] owner with details from our discussion.

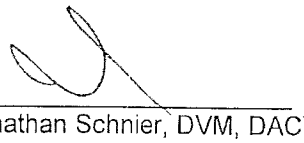
I did not receive any additional calls or reports from 1st Pet or C[redacted] owners on June 25th. I did not contact C[redacted] owner again later in the evening on June 25th as I had expected that this would be handled by the staff at 1st Pet based on my communication with Dr. Meredith. As C[redacted] was undergoing treatment and monitoring at their facility and I was unable to examine C[redacted], myself or obtain current updates, I felt that it was best that communication came directly from the attending veterinary staff.

BluePearl's communication records indicate that Frederick Milens called and spoke with our reception desk to cancel a technician appointment scheduled for June 26th. This communication was recorded in C[redacted] record at 4:06 PM on June 25th.

On Monday June 29th, I had not heard anything regarding C[redacted] from either his owners or 1st Pet. No additional records or updates were received following my conversations with 1st Pet on June 25th. I contacted 1st Pet and I was informed that C[redacted] was taken home with plans for euthanasia at home or at another facility.

I called and spoke with Mr. Milens on June 30th. I noted that we had called 1st Pet on June 29th as we had not received updated information regarding C[redacted] status. I discussed that during the phone call, the staff at 1st Pet had informed us that C[redacted] was taken home to be euthanized. Mr. Milens confirmed that

C[redacted] had been humanely euthanized. I provided my condolences and noted that Mr. Milens could call with any questions in the future. This was the extent of my involvement in this matter. In retrospect I feel all of the veterinary care I provided was in full compliance with the standard of care and, in terms of my communications and interactions with the owners, I again feel that I went above and beyond what another veterinarian would have done. Thank you.



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